STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

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R000000	This visit was for a State Licensure survey. Survey dates: June 2 & 3, 2014 Facility number: 011970 Provider number: 011970 AIM number: N/A Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Tina Smith-Staats, RN Toni Maley, BSW Census bed type: Residential: 45 Total: 45 Census payor type: Medicaid: 21 Other: 24 Total: 45 Sample: 11 These state findings are in accordance with 410 IAC 16.2-5. Quality review completed by Debora Barth, RN.	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify the physician of weight gain in accordance with his orders for 1 of 7 residents reviewed for physician notification in a sample of 11. (#R21) Findings include: The clinical record for Resident #R21 was reviewed on 6/2/14 at 10:36 a.m. Diagnoses for Resident # R21 included, but were not limited to, hypertension, congestive heart failure, and diabetes. A physician's order, dated 1/6/14, indicated Resident #R21 was to be weighed daily. The physician was to be notified if the resident had a weight gain of greater than 2 pounds overnight or a 5 pound weight gain in a week. Review of the March, April, and May,	R000036	Resident 21's weight will be taken daily. The staff member who weigh's resident 21 will give the information to the Director of Nursing or her designee. The Director of Nursing or her designee will keep a daily log of Resident 21's weight. The physician will be notified according to physician orders. An audit will be done of all residents to find any other residents who have orders for daily weights to assure the physicians'orders are being followed. To provide greatest consistency to this process, the following system changes have been adapted: Any resident who requires daily weights will be asked to supply themselves with a digital scale in their apartment. This will help standardize the weights taken. The directions for taking the daily weights will be added to the C.N.A. assignment sheet. An inservice will be done to review new process with nursing staff. The Administrator or her	07/01/2014

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	2014 Medication Administration Records (MARs) indicated the following daily weights: 3/4/14 - 128 pounds (lbs.) and 3/5/14 - 131 lbs., a weight gain of 3 lbs overnight. 3/12/14 - 128 lbs. and 3/13/14 - 132 lbs., a weight gain of 4 lbs overnight. 4/8/14 - 123 lbs. and 4/13/14 - 128 lbs., a weight gain of 5 lbs in a week. 4/15/14 - 125 lbs. and 4/16/14 - 128 lbs., a weight gain of 3 lbs overnight. 5/22/14 - 132 lbs. and 5/23/14 - 135 lbs., a weight gain of 3 lbs overnight. 5/30/14 - 130 lbs. and 5/31/14 - 134 lbs, a weight gain of 4 lbs overnight. The clinical record lacked any documentation of the physician having been notified of the weight gains for Resident #R21 on 3/5/14, 3/13/14, 4/13/14, 4/16/14, 5/23/14, and 5/31/14. During an interview with the Director of Nursing (DoN) on 6/3/14 at 9:47 a.m., additional information related to physician notification of weight gains for Resident #R21 was requested. The facility failed to provide any additional information as of exit on 6/3/14. Review of the undated current facility		designee will monitor the system to assure it is being followed. The plan of correction will be implemented by July 1, 2014	

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	policy, titled "ADMINISTRATION OF MEDICATIONS GENERAL GUIDELINES", provided by the Administrator on 6/3/14 at 2:20 p.m., included, but was not limited to, the following: "...Staff will communicate with the resident's physician as necessary regarding the monitoring of parameters, lab tests, and changes in conditions...."			
R000050	410 IAC 16.2-5-1.2(t)(1-10) Residents' Rights - Noncompliance (t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident			

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	' s funds given the facility for safekeeping; (5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars ($100) in an interest-bearing account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars ($100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds; (10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a final accounting of those funds			

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	to the individual or probate jurisdiction administering the resident ' s estate. Based on interview and record review, the facility failed to have signed consent from residents in order to manage funds, provide quarterly statements to those for whom they managed funds and use acceptable accounting practices for 4 of 4 residents who were reviewed for the management of resident funds (Resident #R38, #R39, #R26 and #R13). Findings include: During a 6/2/14, 2:20 p.m., review of resident funds the following concerns were noted: a.) The facility managed funds for four residents (Residents #R38, #R39, #R26 and #R13). None of the four residents had signed consents for the facility to manage personal funds. b.) None of the four residents had been given quarterly statements. c.) None of the four residents had signed receipts for money withdrawn from their account. During a 6/2/14, 2:20 p.m., interview with the Secretary and Administrator, the administrator indicated the residents did	R000050	Residents #38, #39, #26 and #13 will sign an authorization requesting the facility to manage their funds of $100 or less. The facility policy is to not hold funds over $100.00. Residents or their responsible Party will sign receipts for all deposits and withdrawal from the account. Each resident's money shall be kept in a separate envelope clearly marked with his or her name. A notebook shall be maintained for the Resident Personal Funds. Each resident's written authorization shall be maintained in the notebook. Also a log detailing each resident's deposits and withdrawals. This log will be given to the residents or their responsible parties as their quarterly report. Petty Cash receipts will be kept for 6 months after they are entered on the log. This system will be put into place for each resident who requests the facility maintain a personal fund for them. The receptionist will be responsible for maintaining the personal funds, writing the receipts, completing the log, and disbursement of the funds. The administrator will monitor system to assure the appropriate procedures are being followed. The plan of correction will be in place by 7/1/14. Attachments: Personal Fund Account Disbursement Receipt,Management of Personal	07/01/2014

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	not sign consents for the facility to manage funds, the facility did not provide quarterly statements and the residents did not sign receipts when withdrawing funds from their accounts. The facility did not have policies and procedures for the management of resident funds. The facility had been managing personal/resident funds "for a while now."		Funds Policy, Personal Fund Account Agreement, Personal Funds Disbursement Record	
R000216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to insure a resident who self administered medications had a current assessment for the self administration of medication for 1 of 1 residents reviewed for self medication administration (Resident #R29). Findings include:	R000216	Resident 29 shall have a new Self- Medication Administration of Medication Assessment completed by 7/1/14. An audit will be completed to identify all other residents who self administer medications and assure that they have a recent new Self-Medication Administration of Medication Assessment. For all residents	07/01/2014

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	Resident #R29's record was reviewed on 6/2/14 at 10:50 a.m. Resident #R29's current diagnoses included, but were not limited to, arthritis, psoriasis and spinal stenosis. Resident #R29 had a current, 10/14/13, physician's order permitting her to self administer Tylenol P.M. Resident #R29 had a 2009 self administration of medication assessment. The record did not have a more current assessment available. During a 6/3/14, 12:30 p.m., interview, the Administrator indicated the facility did not have a more recent self administration of medication assessment for Resident #R29. A current, undated, facility policy titled "Medication Administration", which was provided by the Administrator on 6/3/14 at 11:00 a.m., indicated the following: "The resident must be able to perform each step indicated below prior to beginning self-administration of medications. This assessment will be completed upon admission, every 6 months or as needed."		who self administer medications, the Director of Nursing or her designee will complete a Self-Medication Administration of Medication Assessment with the semi annual assessment of needs, and/or upon change of conditions that would warrant a new Self-Medication Administration of Medication Assessment. An inservice with nursing will be held to review this process. The administrator will be responsible to monitor the process to assure it is being followed. The plan of correction will be implemented by7/1/14	
R000296	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance			

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	(b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview and record review, the facility failed to ensure a vial of Tubersol (a medication used to test for TB) was not used 30 days after being opened. This deficient practice affected 2 of 2 residents reviewed for recent TB testing in a sample of 11. (Resident #'s R1 and R2) Findings include: 1. An observation of the refrigerator stored in the Director of Nursing's office was made on 6/3/14 at 1:43 p.m., with the Director of Nursing present. The refrigerator contained a vial of Tubersol solution dated as being opened on 4/17/14. The Director of Nursing indicated she had used solution from the vial to administer TB tests to Resident #R2 on 6/2/14 and Resident #R1 on 6/3/14. She indicated she thought the solution was good until 1/14/2016. The label on the bottle indicated the medication was to be discarded 30 days after being opened.2. Review of the undated current facility policy, titled "ADMINISTRATION OF MEDICATIONS GENERAL GUIDELINES", provided by the	R000296	The TB test for Resident 1 and Resident 2 was re-done with a new vial of Tubersol. An audit will be done to assure that no other residents had TB tests done with the out-dated vial of Tubersol. In the future, the DON or her designee will write on the vial of Tubersol what date the vial should be discarded, according to manufacturer's recommendation. The DON or her designee will be responsible for disposing of outdated Tubersol and ordering a new vial for use as needed An inservice with Nursing will be completed to review this process. The administrator will be responsible to monitor the system to assure compliance. The plan of correction will be implemented by 7/1/14.	07/01/2014

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	Administrator on 6/3/14 at 2:20 p.m., included, but was not limited to, the following: "...EXPIRED MEDICATIONS When medications are expired, the medications must be removed from the resident's apartment/room/ and/or the medication storage area and disposed of. The expiration date of all medications must be checked before administering medications to residents or providing medication assistance... ...Expired medications awaiting return/disposal are stored in a locked, secure area designated for that purpose unit returned to the family/responsible party or disposed of.... ...e. All other multidose injectables expire 30 days after opening unless otherwise stated...."			
R000408	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to ensure residents received a chest x-ray prior to admission for 1 of 2 newly admitted residents reviewed in a sample of 11. (Resident	R000408	Resident 2 had a new chest x-ray completed on . A chart audit will be done to assure that all residents have an admission chest x-ray which complies with state regulations. In the future	07/01/2014

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	#R1) Findings include: Resident #R1's clinical record was reviewed on 6/2/14 at 10:15 a.m. The resident had a Nurse's Note, dated 5/31/14 3:00 p.m., indicating the resident had arrived at the facility and was moving in. The resident's chest x-ray was dated 6/10/11. During an interview with the Administrator on 6/2/14 at 3:00 p.m., she indicated she had not noticed how old the chest x-ray when she reviewed the resident's paperwork. The undated "Pre-Admission Assessment" policy was provided by the Administrator. The policy indicated the following: "...the resident will be required to provide the following: ...Report of a chest x-ray done in the last six months which states the resident is clear of communicable disease...."		the Administrator or her designee will assure that all admission chest-xrays have been completed with-in 6 months of admission. The Director of Nursing or her designee will complete a review of each resident's admission paperwork to assure compliance. The plan of correction will be implemented by7/1/14.	
R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance			

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	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to ensure residents received a Mantoux test for tuberculosis (TB test) prior to or upon admission for 2 of 2 newly admitted residents reviewed in a sample of 11. (Resident #'s R1 and R2) Findings include: 1. Resident #R1's clinical record was reviewed on 6/2/14 at 10:15 a.m. The resident had a Nurse's Note, dated 5/31/14 3:00 p.m., indicating the resident had arrived at the facility and was moving in.	R000410	A new TB test was completed for Resident #1 and Resident#2 on 6/16/14. The administrator will assure that all residents admitted since 6/3/14 will have a TB test completed within the last 3 months prior to admission. An inservice with the nursing department will be held to review this policy. The administrator or her designee will assure that all new admits have a TB test done within the last 3 months ofadmission. The Director of Nursing orher designee will review all new admissions for compliance. The plan of correction will be in place by 7/1/14.	07/01/2014

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	The record lacked an indication of the Mantoux test being given. During an interview with the Administrator on 6/2/14 at 11:20 a.m., she indicated the TB test had not been given. During an interview with the Director of Nursing on 6/3/14 at 12:41 p.m. she indicated she had given Resident #R1 his TB test earlier this morning [6/3/14.] She indicated she was not aware of the resident's need for a TB test until today. She indicated there were no nurses present with the required certification to administer TB tests on 5/31/14, when the resident was admitted to the facility.2. The clinical record for Resident #R2 was reviewed on 6/3/14 at 8:40 a.m. Diagnoses for Resident #R2 included, but were not limited to, hypertension, arthritis, and back pain. The clinical record lacked any documentation of a Tuberculin test having been administered on or prior to admission. Resident #R2 was admitted on 5/31/14. During an interview with the Administrator on 6/3/14 at 8:42 a.m., she indicated the Director of Nursing (DoN) had administered a Tuberculin test the			

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	previous evening for Resident #R2. During an interview with the DoN on 6/3/14 at 9:47 a.m., additional information was requested related to the documentation of the Tuberculin test for Resident #R2. During an interview with the DoN on 6/3/14 at 12:41 p.m., documentation of a Tuberculin test administered on 6/2/14 for Resident #R2 was provided. 3. The undated "Pre-Admission Assessment" policy was provided by the Administrator. The policy indicated the following: "...the resident will be required to provide the following: ...The results of a TB test or an order for one that we will administer, including a second step and annually thereafter...."			